Medicine

User Account Security Form
Merchant Card Applications

User Information (All Fields Required)

The user requiring access to the Merchant Card application must read the policy in this section and provide the requested information, including signature and date.

User's Name: _____ Company Name: _____

Department: _____

Phone: _____ email: _____ Location: _____

Merchant Name: _____ Merchant ID: _____

Application Access: ☒ Payment Navigator ☐ Other _____

The individual requesting access to the Merchant Card application accepts sole responsibility for the assigned account and any action attributed to that account. The individual understands that sharing the account and its password is strictly prohibited by University of Colorado (CU Medicine) policies. When accessing the Merchant Card application, the confidentiality, integrity, and availability of the data and accounts must be safeguarded at all times. All sensitive and confidential information (e.g. credit card information, patient information, etc.) must be protected from unauthorized disclosure. The individual must notify the application administrator and CU Medicine Help Desk if their account is used by another individual or if there is any other breach of security. False, misleading, inaccurate, or damaging data may not knowingly be entered into the Merchant Card application. Confidential information contained or entered into the Merchant Card application must not be accessed or disclosed unless such access or disclosure is part of the individual's normal job duties. Information will remain confidential indefinitely *including after access to the system or employment ends*. Any violation of these security policies may result in account termination and/or legal remedies.

I HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPH AND WILL COMPLY WITH THE RESPONSIBILITIES AND CONFIDENTIALITY OF THE INFORMATION AND RESOURCES MADE AVAILABLE TO ME.

_____ Date: _____

User's Signature

Manager/Sponsor Authorization (All Fields Required)

The manager or sponsor of the user requiring access must sign and date this section of the form.

_____ Date: _____

Sponsor/Manager Signature

Title/Organization: _____ Phone: _____

Reset Form Print Form

Contact paymentnavigatorhelp@cumedicine.us regarding questions or assistance with the completion of this form.
Email completed form to helpdesk@cumedicine.us.

The user will be notified via email or phone with login details upon completion. Please allow 24 hours for the request to be completed.